Directory

• Aetna's Customer Service number:	1-877-292-2480
• Pre-certification number:	1-800-654-7714
• Aetna's website address:	www.aetna.com/docfind/custom/cityofseattle
• Where to submit claims:	Aetna P.O. Box 14089 Lexington, KY 40512-4089
• Plan sponsor:	City of Seattle Personnel Department benefits.unit@ci.seattle.wa.us 206-615-1340

Please note: We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and other legal documents, the legal documents will always govern. The City of Seattle intends to continue these plans indefinitely but reserves the right to amend or terminate them at any time, in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. This booklet does not create a contract of employment with the City of Seattle.

Table of Contents

Part I
Summary of Coverage

Employer: City of Seattle

ASA: 100290

SOC: 9A

Issue Date: July 7, 2003

Effective Date: January 1, 2003

The benefits shown in this Summary of Coverage are available for you and your eligible dependents. The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer (Plan Sponsor).

Eligibility

Retirees

You are in an Eligible Class if you are a retired employee of The City of Seattle, and you

1. retired before the Effective Date of this Plan and were covered under prior coverage through the Employer for Health Expense Coverage on the day before that date; or

2. retired on or after the Effective Date of this Plan and are a:
   - retired member of the Seattle Employees' Retirement System;
   - retired LEOFF I (only dependent coverage provided) or LEOFF II Local 27, International Association of Fire Fighters member;
   - retired LEOFF I (only dependent coverage provided) or LEOFF II member of Local 2898, Fire Chiefs;
   - retired Fire Department non-represented LEOFF I (dependent only coverage) or LEOFF II member; or
   - retired Seattle Housing Authority employee

- you are under the age of 65;
- you had coverage under a medical plan for active employees offered by the Employer at the time of your retirement; and
- you elected to receive retirement benefits immediately after terminating your employment with the Employer; and
- you applied for coverage within 30 days after your employment ceased or COBRA coverage ended without a break in coverage.

Your Eligibility Date is the first day of the first calendar month following the date you retire or the date your COBRA coverage ends, whichever is later, but not before the later of the Effective Date of this Plan or the date you enter the Eligible Class.

You may delay enrollment in this Plan if you are covered as a dependent under a medical plan for active employees with the Employer. When that coverage ends, you must apply for coverage under this Plan within 30 days of the end of the other coverage or COBRA coverage ends without a break in coverage. Your Eligibility Date is the first day of the first calendar month following the date your other coverage or COBRA coverage ends, whichever is later.

You must not have been previously represented by a bargaining group for which a separate Summary of Coverage is available. Your Employer will provide you with this information.

Dependents

Dependents are eligible to be enrolled at the time the Retiree enrolls if:

- the Retiree is in an Eligible Class;
- the Retiree enrolls in a timely manner;
- the Dependent had coverage under a plan for active employees through the Employer at the time of the employee's retirement; and
- the Dependent is under age 65

Dependents are eligible to be enrolled if the Retiree is <u>not</u> enrolled, if one of the following conditions is met:

- the Retiree is age 65 or older and meets the Eligibility requirements, except for the age requirement; or
- the Retiree is under age 65, a LEOFF I member and meets the Eligibility requirements; or
- the Employee died while still employed, but was eligible for a service retirement at the time of death.

You may cover your:

- lawful wife or husband;
- domestic partner who you have named in an Affidavit of Marriage/Domestic Partnership on file with your employer; and
- unmarried children who are under 21 years of age.

Any other unmarried child under age 23 who goes to school on a regular full-time basis at an accredited school and depends primarily on you for support will be covered as a dependent.

Your children include:

- Your biological children
- Your adopted or legally placed for adoption children
- Your stepchildren for whom your home is their permanent residence
- Your domestic partner's children for whom your home is their permanent residence
- Children for whom you are a legal guardian and for whom your home is their permanent residence
- Disabled Dependent Children (see General Information Section)

Proof of dependency may be periodically required by Aetna.

Exceptions

A dependent may also be enrolled after you are first eligible if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible because at that time:
    - the person had coverage through the Employer or another employer; and
    - you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and

- the person loses such coverage because:
    - of termination of employment in a class eligible for such coverage;
    - of reduction in hours of employment;
    - your spouse or domestic partner dies;
    - you and your spouse divorce or are legally separated;
    - you and your domestic partner dissolve your domestic partnership; or
    - the other plan terminates due to the employer's failure to pay the premium or for any other reason

If application for coverage is made within 31 (thirty-one) days of the loss of other coverage, Health Expense Coverage will become effective the first day of the calendar month following receipt of your application and proof of loss of other coverage.

Additional Exceptions

Also, a dependent may be enrolled after you are first eligible if the person is:

- A spouse or child who meets the definition of a dependent by court order, and you elect coverage within 31 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order.
- A dependent you acquire after you were first eligible, who meets the definition of a dependent, through marriage or domestic partnership, and you subsequently elect coverage for any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the marriage or domestic partnership.
- A dependent child you acquire after you were first eligible, who meets the definition of a dependent, through birth, legal guardianship, adoption, or placement for adoption, and you subsequently elect coverage for any such dependent within 60 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of legal guardianship, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

Special Rules Which Apply to an Adopted Child

This Plan does not limit coverage for a preexisting condition for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 60 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If a request is not made within such 60 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to affect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued as part of a judgment, order of decree, a divorce settlement agreement or a legal separation proceeding. Agreements made by the parties, but not formally approved by a court are not acceptable.

You must make written request for such coverage. Coverage for the child will become effective on the date of the court order or the date specified in the court order provided application for coverage is submitted within 31 days of the court order. To be considered qualified, a medical child support order must include:

- name and last known address of the parent who is covered under this Plan;
- name and last known address of each child to be covered under this Plan;
- type of coverage to be provided to each child; and
- period of time the coverage is to be provided.

QMCSOs should be sent to the Employer. Upon receipt, the Employer will notify you if the order is qualified. If the order is qualified, you may cover your child(ren) under the Plan.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Enrollment Procedure

You will get a form to complete. Sign and return it to the Employer within 31 (thirty-one) days of the later of: (a) your date of retirement, (b) the date COBRA coverage ends, or (c) the date your coverage as a dependent under a medical plan for active employees ends. Dependents of a deceased employee must sign and return the form to the Employer within 31 (thirty-one) days of the date of the employee's death.

Your contribution toward the cost of this coverage will be deducted from your pension check and is subject to change. If the contribution amount exceeds the amount of your personal check, you must pay by personal check by no later than the first of the month for that month's coverage.

Effective Date of Coverage

Retirees	Your coverage will take effect on your Eligibility Date.
Dependents	Coverage for your dependents will take effect on the date yours takes effect if you elected coverage for them on your enrollment form or as provided in the Exceptions section of this Summary of Coverage. Also, in order to be sure coverage is in force for any new dependents you acquire, you should report any changes within 31 days following the date of marriage or formation of a domestic partnership, or within 60 days following the date of acquisition of a dependent child. In these instances, coverages will begin on the date of acquisition. This will affect your contributions.

Health Expense Coverage

Retirees and Dependents	Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable. If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract: **Room and board charges:** 40% **Other charges:** 60% This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Basic Vision Care Expense Coverage

Eye exam paid at 100% and no deductible applies. See Vision Care Supplies in Part II for additional benefit payment information.

Prescription Drug Expense Coverage

Payment Percentage
100% as to:

Retail In-network Pharmacy

Generic Drugs	after a copay of 30% of the cost of each 34-day prescription or refill* Some maintenance medication limited to 100 units or a 34-day supply, whichever is greater.
Brand Name Drugs On Medication Formulary	after a copay of 50% of the cost of each 34-day prescription or refill*
Other Brand Name Drugs	after a copay of 50% of the cost of each 34-day prescription or refill*

*Minimum of $10 (or actual cost of the drug if less) and maximum of $100 per prescription

Mail Order In-network Pharmacy

Generic Drugs	after a copay of 30% of the cost of each 90-day prescription or refill*
Brand Name Drugs On Medication Formulary	after a copay of 50% of the cost of each 90-day prescription or refill*

Other Brand Name Drugs	after a copay of 50% of the cost of each 90-day prescription or refill*

*Minimum of $20 (or actual cost of the drug if less) and maximum of $200 per prescription.

No benefits will be provided for drugs dispensed by a pharmacy that is not an In-network Pharmacy, except when specifically provided for in cases of emergency.

Prescription Drug Payment Limit
This limit applies only to Covered Prescription Drug Expenses, except those expenses which are applied against any deductible, fee, or copay amount. Eligible expenses for Retail and Mail Order drugs will accumulate toward the Payment Limit listed below.

Payment Limit which Applies to Expenses for a Person
When a person's Covered Prescription Drug Expenses dispensed by an In-network Pharmacy for which no benefits are paid because of the Payment Percentage reach $1,500 in a calendar year, benefits will be payable at 100% for all his or her Covered Prescription Drug Expenses dispensed by an In-network pharmacy to which this limit applies and which are incurred in the rest of that calendar year.

Payment Limit which Applies to Expenses for a Family
When a family's Covered Prescription Drug Expenses dispensed by an In-network pharmacy for which no benefits are paid because of the Payment Percentage reach $4,500 in a calendar year, benefits will be payable at 100% for all their Covered Prescription Drug Expenses dispensed by an In-network Pharmacy to which this limit applies and which are incurred in the rest of that calendar year.

Comprehensive Medical Expense Coverage

All maximums included in this Plan are combined maximums between In-network Care and Out-of-network Care, where applicable, unless specifically stated otherwise.

Certification Requirement
Hospital Admissions, Mental Disorder Treatment Facility Admissions, Chemical Dependency Treatment Facility Admissions, Convalescent

Facility Admissions, Home Health Care, Hospice Care (inpatient and outpatient), and Skilled Nursing Care must be certified as necessary to avoid a reduction in the benefits payable. If certification is not obtained and the care is not medically necessary, no benefits will be paid. If certification is not obtained and the care is determined to be medically necessary, payment will be based on the appropriate Payment Percentage for the type of service and provider used.

Read the Comprehensive Medical Expense Coverage section of this Booklet for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Benefits Payable
After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the Negotiated Charge or Recognized Charge for the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet. Benefits may vary depending upon whether an In-network Provider is utilized. An In-network Provider is a health care provider who has agreed to provide services or supplies at a "Negotiated Charge." See your Employer for a copy of the Directory which lists these health care providers or access this information at www.aetna.com/docfind/custom/cityofseattle.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Deductible Amounts	
• In-network Care and Other Health Care Calendar Year Deductible	$400
• Out-of-network Care Calendar Year Deductible	$1,000
• In-network Care and Other Health Care Family Deductible Limit	$1,200
• Out-of-network Care Family Deductible Limit	$3,000

This Calendar Year Deductible applies to all expenses except National Medical Excellence Travel and Lodging Expenses.

The Calendar Year Deductible is the amount of covered medical expenses you pay each calendar year before the Plan pays benefits. Besides an individual deductible, there is a maximum calendar year deductible for families. Once your expenses reach the family deductible amount, you will

not have to satisfy any more individual deductibles for the rest of the calendar year, regardless of the size of your family.

Eligible expenses for In-network Care, Out-of-network Care, and Other Health Care will accumulate toward **both** the In-network Care Calendar Year Deductible and the Out-of-network Care Calendar Year Deductible.

The In-network Care and Other Health Care benefits of this Plan will become available to each person after the In-network Care and Other Health Care Calendar Year Deductible of $400 ($1,200 family) has been satisfied, unless specifically stated otherwise. The Out-of-network benefits of this Plan will become available to each person after the Out-of-network Calendar Year Deductible requirement of $1,000 ($3,000 family) has been satisfied, unless specifically stated otherwise.

To satisfy the deductible requirement for a calendar year, the person must incur eligible deductible expenses equal to the deductible amount during the Calendar Year or the last three months of the preceding calendar year, while covered by this contract. The expenses must be for services and supplies that are within the benefits of this contract.

The following amounts will not be considered in satisfying the deductible requirement:

- Expenses for services or supplies not included in the Plan
- The member's share of expenses partially covered by this Plan, including but not limited to any Copays
- Expenses for Out-of-network Care services or supplies in excess of the Recognized Charge
- Expenses for services not subject to the deductible

If two or more covered family members are injured in a common accident, only a single deductible amount needs to be satisfied for all of them to receive coverage for injuries resulting from that accident in the calendar year in which the accident occurred.

If a member is confined as an inpatient at the close of a calendar year for which the deductible has been satisfied and the confinement continues without interruption into the next calendar year, the deductible for the second calendar year will not apply until the member is discharged.

Coordination of benefits will not apply until after your deductible has been satisfied.

Copayment Amounts	
Inpatient Hospital	$500 per admission
Inpatient Convalescent Facility	$500 per admission
Inpatient Chemical Dependency	$500 per admission
Inpatient Mental Disorder Treatment Facility	$500 per admission
Hospital Emergency Room	$100 per admission

The Hospital Emergency Room Copayment applies to all Hospital Expenses for emergency room care. This Copayment is waived if the member is admitted within 24 hours for the same condition.

However, for a confinement of a well newborn child that starts on the day of birth, the Inpatient Hospital Copayment will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

Payment Percentage

The Payment Percentage applies to the Negotiated Charge or Recognized Charge for the incurred expense after any deductible or copayment amounts.

	In-network Care	**Out-of-network Care**	**Other Health Care**
Acupuncture	80%	60%	80%
Ambulance	80%	60%	80%
Blood bank charges	N/A	N/A	80%
Chemical dependency	80%	60%	80%
Chiropractic services	80%	60%	80%
Convalescent facility	80%	60%	80%
Durable medical equipment	80%	60%	80%
Emergency room fees for emergency care	80%	80%	80%
Emergency room fees for non-emergency care	80%	60%	80%
Home health care	80%	60%	80%
Hospice	80%	60%	80%
Hospital fees	80%	60%	80%
Lab & X-ray	80%	60%	80%
Mammography	80%	60%	80%
Mental disorders Inpatient	80%	60%	80%

Outpatient	50%	50%	50%
National Medical Excellence Travel & Lodging Expenses(for organ transplants)	100%	N/A	N/A
Neurodevelopmental therapy	80%	60%	80%
Phenylketonuria Formula	N/A	N/A	100%
Physician fees	80%	60%	80%
Prostheses	80%	60%	80%
Rehabilitative Care (includes physical, speech, occupational and massage therapy)			
Inpatient	80%	60%	80%
Outpatient	80%	60%	80%

To be sure that you will receive the In-network benefit available under this Plan, you should verify the provider's status by calling either the provider or the toll-free number shown on your ID card. In addition, if your In-network Provider is coordinating your care with other providers, ask your In-network provider to use other In-network providers.

Payment Limits which Apply to Expenses for a Person
Eligible expenses for In-network Care, Out-of-network Care, and Other Health Care will accumulate toward **both** of the Payment Limits listed below ($400 and $1,600).

When a person's Covered Medical Expenses for which no benefits are paid reach $400 in a calendar year, benefits will be payable at 100% for In-network medical expenses and 100% of the Recognized Charge for Other Health Care Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year. **Any amount over the Recognized Charge for Other Health Care Medical Expenses is the responsibility of the member.**

When a person's Covered Medical Expenses for which no benefits are paid reach $1,600 in a calendar year, then benefits will be payable at 100% of the Recognized Charge for all of his or her Out-of-Network Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Out-of-network providers do not have a participating contract with Aetna. They have not agreed to waive expenses for covered services that are over the Recognized Charge. Benefits will be paid at the appropriate Out-of-network payment level once the claim is submitted. **You will be responsible for services or supplies which are not covered, any**

amounts over the benefit maximums, and any costs over the Recognized Charge.

The following items do not count toward the Payment Limit: the annual deductible; the copays; the difference between the Recognized Charge and an Out-of-network or Other Health Care actual charge; the difference between the Negotiated Charge and an In-network actual charge; Covered Medical Expenses for outpatient mental disorder treatment, outpatient rehabilitation services (physical, occupational, massage, and speech therapy), and neurodevelopmental therapy treatment; and any balances remaining after a benefit limit has been expended.

If a member is confined on an inpatient basis at the close of a calendar year for which the Payment Limit has been satisfied and the confinement continues without interruption into the next calendar year, the Payment Limit for the second calendar year will not apply until the member is discharged.

Benefit Maximums

Read the coverage section in your Booklet for a complete description of the benefits available. Services used to satisfy the deductible count toward the Benefit Maximums.

Convalescent Maximum	90 days per calendar year
Home Health Care Maximum	130 visits per calendar year
Hospice Care Maximum Inpatient	14 days within 6 consecutive months
Outpatient	120 hours per calendar year
Lifetime Maximum	$10,000 or 6 months, whichever is greater. Extension of benefits is available with authorization.
Respite Care Maximum	240 hours within 6 consecutive months
Neurodevelopmental Therapy Maximum	$ 2,000 per calendar year
Chemical Dependency Combined Inpatient & Outpatient Maximum	$11,285 within 24 consecutive months for inpatient and outpatient combined, including Acupuncture Expenses
Mental Disorder Maximum Inpatient	8 days per calendar year
Outpatient	12 visits per calendar year
Spinal Disorder Treatment Maximum	10 visits per calendar year

Acupuncture Treatment Maximum	12 visits per calendar year, excluding those for chemical dependency treatment
Rehabilitation Services Maximum Inpatient	 $50,000 per condition
Outpatient	$2,000 per calendar year. Additional benefit possible with authorization if inpatient rehabilitation benefit not exhausted.
National Medical Excellence Lodging Expenses Maximum	$50.00 per day per person
Travel and Lodging Maximum	$10,000 per episode of care
Semi-Private Room Limit	The institution's semiprivate rate
Lifetime Maximum Benefit	$1,000,000

Benefits received from one of the employer's medical plans for active employees shall not be used in computing benefit limits under this Plan. The total benefits available to any one member under this Plan during the member's lifetime shall not exceed a cumulative maximum cost of $1,000,000. Each January 1 of the member's continuous coverage the Plan will restore up to $20,000 of this maximum that has been paid and not previously restored. The restoration occurs regardless of the state of your health.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses on the same basis as for a disease. This benefit is not available for dependent children.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID card.

Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage
Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted. Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

Additional Information Provided by the City of Seattle

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour)

stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your ID card.

Part II
Health Expense Coverage

Employer	City of Seattle
ASA:	100290
Booklet Base:	9

Issue Date: July 7, 2003

Effective Date: January 1, 2003

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for eligible expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Basic Vision Care Expense Coverage

They are the charges for any service or supply shown in the Covered Vision Care Schedule and Vision Care Supplies section which is furnished or prescribed by a legally qualified ophthalmologist or optometrist.

Covered Vision Care Service Schedule

Eye Exam
Charges for not more than one complete eye exam, which may include refraction, will be deemed to be covered Vision Care Expenses in a calendar year. No deductible applies.

Lenses
Charges for not more than 2 (two) lenses will be deemed to be covered Vision Care Expenses in a calendar year.

Frames
Charges for not more than one set of frames will be deemed to be covered Vision Care Expenses every two calendar years.

Vision Care Supplies

Lenses
Benefits are payable as follows up to a maximum of two separate lenses each calendar year.

Single Vision Lens	$ 20 per lens
Bifocal Vision Lens	30 per lens
Trifocal Vision Lens	40 per lens
Lenticular Vision Lens	65 per lens
Contact Lens	100 per lens*

*Contact Lenses are provided only for (1) aphakia; or (2) if your vision is correctable to 20/70 or better only by the use of contact lenses. If you elect contact lenses and the above provisions do not apply, the single-lens allowance will be provided.

Frames
Frames.....$ 30 in a 24-month period

Limitations
The following limitations apply.

No benefits will be payable for a charge which is:

- For a vision care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer.
- For a vision care service or supply for which a benefit is provided in whole or in part under any workers' compensation law or any other law of like purpose.
- For special procedures. This means things such as orthoptics or vision training.
- For special supplies. This means things such as nonprescription sunglasses and subnormal vision aids.
- For anti-reflective coatings.
- For tinting.
- For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
- For an eye exam which:

  is required by an employer as a condition of employment; or
  an employer is required to provide under a labor agreement; or

is required by any law of a government.
- For a service or supply received while the person is not covered.

Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet. Certain drugs may be limited to a lesser supply as indicated on the Member's prescription or as determined by Aetna.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by an In-network **pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the In-network **pharmacy's** charge for the drug is more than the **copay** per **prescription** or refill. If a member's card is not presented at the pharmacy, no benefit applies, except in the event of an emergency.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

Benefit Amount
The benefit amount for each covered **prescription drug** or refill dispensed by an **In-network pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **In-network pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **In-network pharmacy** on your behalf.

No benefit will be paid for a **prescription drug** dispensed by an **Out-of-network pharmacy** under this benefit section except for an **emergency condition**, in which case the benefit will be payable at the In-network level of coverage.

Limitations
No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 34 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 34 day supply (or 100 unit doses for certain generic maintenance drugs) per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:
  - fertility drugs;
  - allergy sera or extracts; and Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.
- For any refill of a drug that is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:
  - if the **prescriber** has not specified the number of refills; or
  - if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For any **prescription drug** also obtainable without a **prescription** on an "over the counter" basis.
- For replacement prescriptions resulting from loss, theft, or breakage.
- For oral progesterone compounded products.
- For drugs or medications used for cosmetic purposes.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any fertility drugs.
- For any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy,

including but not limited to:
- ─ sildenafil citrate;
- ─ phentolamine;
- ─ apomorphine;
- ─ alprostadil; or
- ─ any other prescription drug that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.

This limitation applies whether or not the **prescription drug** is delivered in oral, injectable, or topical (including, but not limited to, gels, creams, ointments, and patches) forms.

- For more than one 90 day supply of any smoking cessation aids or drugs per lifetime.
- For appetite suppressants and drugs for weight loss.
- For general and injectable vitamins, except legend vitamins will be provided for prenatal care.
- For growth hormones (covered under Medical Expenses for certain conditions only).
- For drugs provided for chemical dependency treatments (covered under Chemical Dependency Treatment benefit).
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not an In-network **pharmacy**.

Comprehensive Medical Expense Coverage

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses
Inpatient Hospital Expenses
Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any **charge** for daily **board and room** in a semi-private room over the Semi-Private Room Limit.

Outpatient Hospital Expenses
Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

Convalescent Facility Expenses
Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a semi-private room over the Semi-Private Room Limit.
- Use of special treatment rooms
- X-ray and lab work
- Physical, occupational or speech therapy
- Oxygen and other gas therapy
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physicians** services.
- Medical supplies

Benefits will be paid up to the Convalescent Maximum during any one calendar year.

Limitations To Convalescent Facility Expenses
This section does not cover charges made for treatment of:

- Drug addiction
- Chronic brain syndrome
- Chemical dependency
- Senility
- Mental retardation
- Any other mental disorder

Home Health Care Expenses
Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and

- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available
- Part-time or intermittent home health aide services for patient care
- Physical, occupational, and speech therapy
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:
  - medical supplies
  - drugs and medicines prescribed by a **physician**; and
  - lab services provided by or for a **home health care agency**.

Benefits will be paid up to the number of visits of the Home Health Care Maximum during any one calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses
This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family
- Services of a social worker
- Transportation
- Custodial care

Hospice Care Expenses
Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses
The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;
- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for pain control; and other acute and chronic symptom management.
- Not included is any **charge** for daily **board and room** in a semi-private

room over the Semi-Private Room Limit. Also not included is the charge for any day of confinement in excess of the 14-day Maximum Limit for all confinements for **Hospice Care** within a 6 month consecutive period.

- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by an **R.N.** or **L.P.N.**
- Medical social services under the direction of a physician. These include: Assessment of the person's social, emotional, and medical needs; and the home and family situation; identification of the community resources which are available to the person; and assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling
- Consultation or case management services by a **physician**
- Physical and occupational therapy
- Part-time or intermittent home health aide services. These consist mainly of caring for the person.
- Medical supplies
- Drugs and medicines prescribed by a **physician**
- Respite Care—Not more than the Respite Care Maximum will be paid. This is 4 or more hours of care furnished during a period of time when no skilled care is required and the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:
  - physical and occupational therapy;
  - part-time or intermittent home health aide services for 4 or more hours in any one day; these consist mainly of caring for the person;
  - medical supplies;
  - drugs and medicines prescribed by a **physician**; and
  - psychological and dietary counseling.

Not more than the Hospice Care Outpatient Maximum will be paid for all Hospice Care Expenses incurred while the person is not confined as a full-

time inpatient. However, an extension of hours is available with preauthorization.

Lifetime Maximum
Not more than the Hospice Care Lifetime Maximum will be paid for all Hospice Care Expenses.
Not included are charges made:

- For bereavement counseling
- For funeral arrangements
- For pastoral counseling
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care except as stated under Other Expenses.

Neurodevelopmental Therapy Expenses
The charges made for the services of a **physician** for rendering Neurodevelopmental Therapy Services are included as Covered Medical Expenses for your dependent child under age 7.

Neurodevelopmental Therapy Services means speech therapy, physical therapy or occupational therapy given to:

- restore or improve a speech or body function; or
- develop a speech or body function delayed by a neurological disease; or
- maintain a speech or body function if, without therapy, a neurological disease would cause significant deterioration in the person's condition.

Not more than the Neurodevelopmental Therapy Maximum will be considered Covered Medical Expenses for each person during any calendar year.

Not included are charges for services rendered by a person who resides with you or who is part of your family.

The dependent child is not eligible for both this benefit and the rehabilitative benefits of this Plan for the same condition and services.

Other Medical Expenses
- Charges made by a **physician**.
- Charges made by an **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care. As used here, "skilled nursing care" means visiting

nursing care by an **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

Not included as "skilled nursing care" is:

a. that part or all of any nursing care that does not require the education, training, and technical skills of an **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or
b. any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or
c. care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
d. care provided solely for skilled observation except as follows:
   - for no more than one 4-hour period per day for a period of no more than 10 consecutive days following the occurrence of:
   - change in patient medication;
   - need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;
   - surgery; or
   - release from inpatient confinement; or
   - any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by an **R.N.** or **L.P.N.**

- Charges for the following:
  a. Diagnostic lab work and X-rays
  b. X-ray, radium, and radioactive isotope therapy
  c. Anesthetics and oxygen
  d. Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given. Air Ambulance is covered. Benefits for licensed air ambulance service will be provided to the nearest Hospital equipped to render the necessary treatment as determined by Aetna, upon review and approval by Aetna. Non-emergency use of ambulance services must be pre-authorized.
  e. Artificial limbs and eyes. Not included are such things as eyeglasses; vision aids; hearing aids; communication aids; and orthopedic shoes, foot orthotics, or other devices to support the feet.

Durable Medical Equipment Expenses
Charges for rental of **durable medical and surgical equipment** are Covered Medical Expenses. In lieu of rental, the following may be covered:

- The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.
- Repair of purchased equipment.
- Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Durable Medical Equipment for which a claim has been submitted and paid while the person is covered under this Plan and delivered within 30 days after termination of coverage will be provided.

National Medical Excellence Program ® (NME)
The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that cannot be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses
These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses
These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with

any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum
For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:
  - one year after the day the procedure is performed; and
  - the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Lifetime Maximum Benefit.

Limitations
Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Explanation of Some Important Plan Provisions

Inpatient Copayment
This is the amount of Inpatient Expenses you pay for each **hospital, convalescent facility, mental disorder treatment facility,** and/or **chemical dependency treatment facility** confinement of a person. Expenses used to meet the Inpatient Copayment cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Copayment.

Calendar Year Deductible
This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Deductible Carryover
Effective 2002, Covered Medical Expenses incurred during the last 3 months of the calendar year will be applied to the deductible for the following calendar year.

Family Deductible Limit
If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Hospital Emergency Room Copayment
A separate Hospital Emergency Room Copayment applies to each visit by a person in a **hospital** emergency room unless the person is admitted to the **hospital** as an inpatient within 24 hours after a visit to a **hospital** emergency room.

Lifetime Maximum Benefit
Benefits received from one of the Employer's medical plans for active employees shall not be used in computing benefit limits under this Plan. The total benefits available to any one member under this Plan during the member's lifetime shall not exceed a cumulative maximum cost of $1,000,000. Each January 1 of the person's continuous coverage, the Plan will restore up to $20,000 of the $1,000,000 Lifetime Maximum Benefit that has been paid and not previously restored. The restoration occurs regardless of the state of your health. This is the most that will be payable for any person in his or her lifetime.

Limitations

Routine Mammogram
Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female for one mammogram each calendar year.

Acupuncture Expenses
The charges made for acupuncture services given to a person by:

- a **physician**; or
- an acupuncturist certified by the American Association of Acupuncture and Oriental Medicine who is practicing within the scope

of both the certification and the laws of the jurisdiction where treatment is given;

are Covered Medical Expenses. Benefits will not be payable for more than the Acupuncture Treatment Maximum.

Acupuncture services are those services rendered:

- as a form of anesthesia in connection with surgery that is covered under this Plan;
- to treat a **disease** or injury; or
- to alleviate chronic pain.

Mouth, Jaws, and Teeth
Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

Repair of teeth due to accidental injury—The services of a licensed dentist for repair of accidental injury to natural teeth that are whole and functionally sound or have been restored to a sound functional capacity will be covered, for the treatment of the injury for a period of 12 consecutive months after the date of injury to a maximum allowance of $600 per occurrence. The services of a licensed denturist will also be covered if the service would be covered if provided by a licensed dentist (D.M.D. or D.D.S.). A licensed denturist means a person licensed as a denturist under RCW Chapter 18 and acting within the scope of his or her license. Payment will be based on the Recognized Charge; any additional charges will be the person's responsibility. This benefit will not be provided for injury caused by biting or chewing. No other charges of a dentist will be covered under this Plan, except when specifically provided otherwise.

Hospitalization for dentistry—The physician and hospital benefits of this Plan will be provided to an inpatient for dentistry if hospitalization is medically necessary to safeguard the person's health, subject to the precertification approval procedures. No benefits will be provided under this paragraph for charges of a dentist; or hospitalization for myofascial pain syndrome and any related appliances; or hospitalization for malocclusions or other abnormalities of the jaw, including but not limited to services for temporomandibular joint disorders.

Surgery needed to treat a fracture, dislocation, or wound, or to cut out cysts, tumors, or other diseased tissues.

Non-surgical treatment of infections or diseases. This does not includes those of or related to the teeth.

Rehabilitation Services
Covered Medical Expenses incurred for rehabilitative services are subject to certain limitations. Rehabilitative services are:

- speech therapy;
- occupational therapy;
- physical therapy; and
- massage therapy

provided by a:

- hospital or licensed health care facility
- physician
- licensed or certified physical, occupational, massage or speech therapist

Rehabilitation Services are therapy which are expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to an injury, disease or a congenital defect.

Benefits will not be payable for more than the Rehabilitation Services Inpatient Maximum for a person who is confined as a full-time inpatient.

As to services which are provided while a person is not confined as a full-time inpatient, benefits will not be payable for more than the Rehabilitation Services Outpatient Maximum for Physical, Massage, Occupational, and/or Speech Therapy for a person in any one calendar year.

A Physician's medical order is required prior to the receipt of outpatient services for Physical, Massage, and/or Occupational Therapy.

The person or provider may apply to Aetna for additional benefits beyond the Rehabilitation Services Outpatient Maximum if:

- the person had a prior inpatient rehabilitative admission for the condition;
- did not exhaust the Rehabilitation Services Inpatient Maximum; and
- the treatment is determined to be medically necessary.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- Services rendered by a physical, massage, occupational, or speech therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from disease; injury; or congenital defect.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.
- Treatment for which a benefit is or would be provided under the Spinal Disorder Treatment section, whether or not benefits for the maximum number of visits under that section have been paid.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- details the treatment to be rendered and the frequency and duration of the treatment;
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Spinal Disorder Treatment
There is a calendar year benefit maximum which applies to Covered Medical Expenses incurred for:

- manipulative (adjustive) treatment; or
- other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine when performed by an approved provider if the service is within the lawful scope of the provider's license.

Not more than the Spinal Disorder Treatment Maximum will be payable in any one calendar year for all expenses in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating **physician**.

Certification For Hospital Admissions
If a person becomes confined in a **hospital** as a full-time inpatient, and

- certification has been requested and denied, or
- certification has not been requested and the confinement is not **necessary**;

no benefits will be paid for any expenses, including hospital room and board and physician services.

If a person becomes confined in a hospital as a full-time inpatient, and

- certification has not been requested, and
- the confinement is **necessary**,

benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan or are determined to be not **necessary**.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency admission** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician**, or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Certification For Convalescent Facility Admissions, Home Health Care Expenses, Hospice Care Expenses, and Skilled Nursing Care

If a person incurs expenses while confined in a **convalescent facility;** or for home health, hospice or skilled nursing care, and

- certification has been requested and denied, or
- certification has not been requested and the convalescent facility confinement, or home health care services, hospice care services, or skilled nursing care services are **not necessary**;

no benefits will be paid for any expenses.

If a person becomes confined in a convalescent facility or incurs expenses for home health care services, hospice care services, or skilled nursing care services, and

- certification has not been requested, and
- the convalescent facility confinement, home health care, hospice care or skilled nursing care services are **necessary**,

benefits will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan, or are determined to be not **necessary**.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you, the provider, or the facility must call to certify more days of confinement or services or supplies. This must be done no later than on the last day that has already been certified.

Prompt written notice will be provided to you and your provider of the days of confinement and services or supplies which have been certified.

Certification For Hospital and Treatment Facility Admissions for Chemical Dependency or Mental Disorders

If a person becomes confined as a full-time inpatient in a **hospital** or **treatment facility** for treatment of chemical dependency or mental disorder, and

- certification has been requested and denied, or
- certification has not been requested and the confinement is not **necessary**;

no benefits will be paid for any expenses, including hospital or facility room and board and physician services.

If a person becomes confined in a hospital or treatment facility as a full-time inpatient, and

- certification has not been requested, and
- the confinement is **necessary**,

benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan or are determined to be not necessary.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency admission** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, you, the **physician**, or the **hospital** or **treatment facility** may request that more

days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital** or **treatment facility**. A copy will be sent to you and to the **physician**.

Treatment of Chemical Dependency, or Mental Disorders
Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment
If a person is a full-time inpatient either:

- in a **hospital**; or
- in a treatment facility;

then the coverage is as shown below.

Hospital
Expenses for the following are covered:

- Treatment of the medical complications of chemical dependency. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Treatment of chemical dependency**.
- Treatment of **mental disorders**.

Treatment Facility
Certain expenses for the **treatment of chemical dependency** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a semi-private room over the Semi-Private Room Limit.
- Other **necessary** services and supplies.

A separate Inpatient Mental Disorder Maximum applies to the **hospital** and **treatment facility** expenses described above for the treatment of **mental disorders** in any one calendar year.

A separate Chemical Dependency Combined Inpatient and Outpatient Maximum applies to all expenses for the **treatment of chemical dependency** incurred in any 24 consecutive month period.

Outpatient Treatment

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

- Expenses for the **treatment of chemical dependency** or the treatment of **mental disorders** are covered.
- For such treatment given by a **hospital, treatment facility** or **physician**, benefits will not be payable for more than the Outpatient Mental Disorder Maximum in any one calendar year for the treatment of mental disorders.
- A separate Chemical Dependency Combined Inpatient and Outpatient Maximum applies to all expenses for the **treatment of chemical dependency** incurred in any 24 consecutive month period.

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those to the extent they are not Recognized Charges, as determined by Aetna.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
  - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - if required by the FDA, approval has not been granted for marketing; or
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
  - the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying

substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays, except as stated under the Neurodevelopmental Therapy Expenses benefit.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- Those for services and supplies:
  - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
  - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:
  - sildenafil citrate;
  - phentolamine;

- apomorphine;
- alprostadil; or
- any other drug that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.

This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.

- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, embryo transfer procedures, or other artificial means of contraception, except to the extent coverage for such procedures is specifically provided in your Booklet.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling
- Those for or in connection with speech therapy, except as provided under the Neurodevelopmental Therapy Expenses benefit. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
  a. Improve the function of a part of the body that is not a tooth or structure that supports the teeth; and is malformed as a result of a severe birth defect; including harelip, webbed fingers, or toes; or as a direct result of disease; or surgery performed to treat a disease or injury.
  b. Repair an injury. Surgery must be performed in the calendar year of the accident which causes the injury, or in the next calendar year.
- Those for cochlear implants, unless preauthorized by Aetna, and

hearing aids

- Those for or in connection with surgery, treatment, programs, or supplies that are intended to result in weight reduction, regardless of diagnosis.
- Those for dyslexia treatment, except as specified in the Neurodevelopmental Therapy Expense benefit; visual analysis, therapy or training, or orthoptics.
- Those for equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; corrective shoes; enuresis equipment; hearing aids; heating pads; weights; adjustable beds; orthopedic chairs; over-the-counter arch supports; orthotics; personal hygiene items; and telephone alert systems.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by an **In-network Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.
- Those for services provided by a family member.
- Those for the treatment of temporomandibular joint syndrome, whether the services are considered to be medical or dental in nature.
- Those for upper and lower jaw bone surgery, except as needed for acute traumatic injury or cancer; orthognathic surgery; jaw alignment; myofascial pain syndrome; malocclusions or other abnormalities of the jaw.
- Those for services and supplies for smoking cessation programs and the treatment of nicotine addiction, except as provided in the Prescription Drug benefit..

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   • secondary to the plan covering the person as a dependent; and
   • primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   • covers the person as other than a dependent; and
   • is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
   c. If there is not such a court decree:
      - If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
      - If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.
- This definition does not include accident-only coverage for preschool, grammar school, high school, or college students, including athletic injuries, either on a 24-hour basis or a "to and from school" basis.

Effect of Medicare

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be determined before benefits are available under Medicare.

Health Expense Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:
  - having refused it;
  - having dropped it; or
  - having failed to make proper request for it.

These are the changes:

- The total amount of "regular benefits" under all Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules.
- Any benefits under Medicare will not be deemed to be an "Allowable Expenses".

If it is necessary in order to administer this provision, Aetna has the right to:

- release or obtain data; and
- make or recover any payments.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When the group contract terminates as to the coverage
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your eligibility ceases for the purposes of termination of coverage under this Plan. This date will be the later of the date you cease to be in an Eligible Class or the day before the next premium due date following the date you cease to be in an Eligible Class.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract
- When a dependent becomes covered as an employee, unless dependent status is maintained under this Plan through a spouse's or domestic partner's coverage
- When such person is no longer a defined dependent
- When your coverage terminates, and you are under age 65.

Disabled Dependent Children

Health Expense Coverage for your fully disabled child may be continued past the maximum age for a dependent child if the child has not been issued a personal medical conversion policy.

Your child is fully disabled if:

- he or she is not able to earn his or her own living because of developmental or physical disability which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully disabled must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the disability
- Failure to give proof that the disability continues

- Failure to have any required exam
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

Aetna will have the right to require proof of the continuation of the disability. Aetna also has the right to examine your child as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age.

Health Expense Benefits After Termination

If a person is hospitalized when his or her Health Expense Coverage ceases, benefits will be available to such person while he or she continues to be hospitalized up to the applicable period shown below.

Health Expense benefits will be available to him or her while hospitalized for up to 12 months.

Health Expense benefits will cease on the first to occur of the following:

- The person's Lifetime Maximum Benefit is paid.
- The person ceases to be hospitalized.
- The person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

If this provision applies to you or one of your covered dependents, see the Conversion of Medical Expense Coverage section and the Continuation of Coverage under Federal Law section for information which may affect you.

Conversion of Medical Expense Coverage

This Plan permits certain persons whose Medical Expense Coverage has ceased to convert to a personal conversion policy. No medical exam is needed. Your dependents who are under age 65 can apply if they cease to be a dependent as defined in this Plan.

The personal policy must be applied for within 31 days after coverage ceases. The 31 days start on the date coverage actually ceases even if the person is still eligible for benefits because the person is hospitalized.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:

- any other hospital or surgical expense insurance policy;
- any hospital service or medical expense indemnity corporation subscriber contract;
- any other group contract;
- any statute, welfare plan or program;
- and that with the converted policy, would result in overinsurance or match benefits.

No one has the right to convert if he or she has been covered under this Plan for less than 3 months. Also, no person has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this Plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your Employer's conversion plan.

It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after the person's coverage ceases.
- A statement that Aetna may ask for data about the person's coverage under any other plan. This may be asked for on any premium due date of the personal policy. If the person does not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If your dependent wants to convert:

- Ask your Employer for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

	The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage. The personal policy will take effect on the day after coverage terminates under this Plan.
Type of Coverage	Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered. Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.
Physical Examinations	Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.
Legal Action	No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.
Additional Provisions	In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force. This document describes the main features of this Plan. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer. Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.
Assignments	Coverage may be assigned only with the written consent of Aetna.

Recovery of Benefits Paid

As a condition to payment of benefits under this Plan for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plan shall, to the extent of benefits it has paid, be subrogated to (has the right to pursue) all rights of recovery of covered persons against:
  - such third party; or
  - a person's insurance carrier in the event of a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy.

- The Plan shall have the right to recover from the covered person amounts received by judgment, settlement, or otherwise from:
  - such third party or his or her insurance carrier; or
  - any other person or entity, which includes the auto insurance carrier which provides the covered person's uninsured or underinsured auto insurance coverage.

- The covered person (or person authorized by law to represent the covered person if he or she is not legally capable) shall:
  - execute and deliver any documents that are required; and
  - do whatever else is necessary to secure such rights.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your Employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as

possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 15 months after the date of the service.

Claim Filing and Appeal Procedures

Filing Health Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

"Urgent Care" means services received for a sudden illness, injury or condition that is not an emergency condition but requires immediate outpatient medical care that cannot be postponed. An urgent situation is one that is severe enough to require prompt medical attention to avoid serious deterioration of a person's health; this includes a condition that would subject a person to severe pain that could not be adequately managed without prompt treatment.

For claims which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing "urgent care" claims, you will be notified of the failure within 24 hours and of the proper procedures to be followed. The notice may be oral unless you request written notification.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days and of the proper procedures to be followed. The notice may be oral unless you request written notification.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Appeal Procedure – Standard Appeals
You have the right to file an appeal about coverage for service(s) you have received from your health care provider or Aetna if you are not satisfied

with the outcome of the initial determination and the appeal is regarding a change in the decision for the following:

- Certification of health care services
- Claim payment
- Plan interpretation
- Benefit determination
- Eligibility

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on the back of your ID card. Your request should include the group name (that is, your employer), your name, Social Security Number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

Your appeal will be acknowledged within five working days of receipt. An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

Payment of Benefits

Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, this Plan has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

This Plan may pay up to $1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges
Charges made by an institution for board and room and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

Brand Name Drug
A **prescription drug** which is protected by trademark registration

Chemical Dependency Treatment Facility
This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **treatment of chemical dependency**.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**.
- Provides, on the premises, 24 hours a day:
  - Detoxification services needed with its treatment program.
  - Infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.
  - Supervision by a staff of **physicians**.
  - Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Companion
This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility
This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - physical restoration services to help patients to meet a goal of self-care in daily living activities.

- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**

- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for chemical dependency services, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay(ment)
This is a fee, charged to a person, which represents a portion of the applicable expense.

As to a **prescription drug** dispensed by an **In-network pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed. For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the **prescription**, kit, or refill.
It is specified in the Summary of Coverage.

Custodial Care
This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist
This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory
This is a listing of all **In-network Providers** for the class of employees of which you are a member. A current list of participating providers is available through Aetna's on-line provider directory, DocFind, at www.aetna.com/docfind/custom/cityofseattle.

Durable Medical and Surgical Equipment
This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;

- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; corrective shoes; enuresis equipment; hearing aids; heating pads; weights; adjustable beds; orthopedic chairs; over-the-counter arch supports; orthotics; personal hygiene items; and telephone alert systems.

Emergency Admission
One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
  - placing the person's health in serious jeopardy; or
  - serious impairment to bodily function; or
  - serious dysfunction of a body part or organ; or
  - in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care
This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Condition
This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or

- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Generic Drug
A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency
This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or an **R.N**.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan
This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

Hospice Care
This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

Hospice Care Agency
This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  - skilled nursing services; and
  - medical social services; and
  - psychological and dietary counseling.

- Provides or arranges for other services which will include:
  - services of a **physician**; and
  - physical and occupational therapy; and
  - part-time home health aide services which mainly consist of caring for **terminally ill** persons; and

- inpatient care in a facility when needed for pain control and acute and chronic symptom management.

- Has personnel which include at least:
  - one **physician**; and
  - one **R.N.**; and
  - one licensed or certified social worker employed by the Agency.

- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Has a full-time administrator.

Hospice Care Program
This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:
  - a **physician** attending the person; and
  - appropriate personnel of a **Hospice Care Agency**.

- Is designed to provide:
  - palliative and supportive care to **terminally ill** persons; and
  - supportive care to their families.

- Includes:
  - an assessment of the person's medical and social needs; and
  - a description of the care to be given to meet those needs.

Hospice Facility
This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.

- Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital
This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for chemical dependency services, or a nursing home.
- Makes charges.

In-network Care
This is a health care service or supply furnished by:

- an **In-network Provider**; or
- a health care provider that is not an **In-network Provider** for an **emergency condition** when travel to an **In-network Provider** is not feasible.

In-network Provider
This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as an **In-network Provider** for:

- the service or supply involved; and
- the class of employees of which you are member.

In-network Pharmacy
A **pharmacy,** including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

L.P.N.
This means a licensed practical nurse.

Mail Order Pharmacy
An establishment where **prescription drugs** are legally dispensed by mail.

Medication Formulary
A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both **brand name drugs** and **generic drugs** and is subject to periodic review and modification by Aetna. See your Employer for a current listing.

Mental Disorder
This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Chemical dependency
- Schizophrenia
- Bipolar disorder
- Pervasive Mental Developmental Disorder (Autism)
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

For the purposes of benefits under this Plan, mental disorder will include chemical dependency only if any separate benefit for a particular type of treatment does not apply to chemical dependency.

Mental Disorder Treatment Facility
This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.

- Makes charges.
- Meets licensing standards.

NME Patient
This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary
A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who is part of his or her family; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge
This is the maximum charge an **In-network Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease
A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Non-urgent Admission
One which is not an **emergency admission** or an **urgent admission**.

Orthodontic Treatment
This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment due to an accident:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Other Health Care
This is a health care service or supply that is neither **In-network Care** or **Out-of-network Care**, and is paid at the In-network Payment Percentage due to geographical limitations or provider availability. Any amount over the In-network Negotiated Charge for services or supplies is the responsibility of the member.

Out-of-Network Care
This is a health care service or supply furnished by a health care provider that is not an **In-network Provider**; if, as determined by Aetna:

- the service or supply could have been provided by an **In-network Provider**; and
- the provider is of a type that falls into one or more of the categories of providers listed in the Directory.

Out-of-Network Provider
This is a health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**.

Out-of-network Pharmacy
A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

Pharmacy
An establishment where **prescription drugs** are legally dispensed.

Physician
This means a legally qualified physician.

Prescriber
Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs
Any of the following:

- A drug, biological, or compounded **prescription** which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription** drug.
- Disposable diabetic supplies.

R.N.
This means a registered nurse.

Recognized Charge
Only that part of a charge which is recognized is covered. The recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the Recognized Charge Percentage made for that service or supply. The Recognized Charge Percentage is the charge determined by Aetna on a semiannual basis to be in the 70th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

In determining the Recognized Charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the recognized charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the Recognized Charge is the rate established in such agreement.

Semiprivate Rate
This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Terminally Ill
This is a medical prognosis of 6 months or less to live.

Urgent Admission
One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Continuation of Coverage under Federal Law

In accordance with federal law (PL 99-272) as amended, your Employer is providing covered persons with the right to continue their health expense coverage under certain circumstances.

You or your dependents may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A or B below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage, or, as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month.

Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility

If your coverage would terminate due to:

- termination of your employment for any reason other than gross misconduct; or
- your loss of eligibility under this Plan due to a reduction in the number of hours you work;

you may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue his or her own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs you or your eligible dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event which would have caused coverage to terminate.
- The end of a 29-month period after the date of the event which would have caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to your Employer, in accordance with section D below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event which would have caused coverage to terminate. Coverage may be continued: for the individual determined to be disabled; and for any family member (retiree or dependent) of the disabled individual for whom coverage is already being continued; and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.

- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the individual becomes enrolled in benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
- As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled; but in no event shall such coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage Under Other Circumstances

If coverage for a dependent would terminate due to:

- your death;
- your divorce or termination of domestic partnership;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- the dependent's ceasing to be a dependent child as defined under this Plan; or
- the dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare;

the dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs your dependents, subject to any notice requirements in section D below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event which would have caused coverage to terminate.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to your dependents under another plan sponsored by your Employer.
- The date any required contributions are not made.

- The first day after the date of the election that the dependent becomes covered under another group health plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

C. Multiple Qualifying Events

If coverage for you or your dependents is being continued for a period specified under section A, and during this period one of the qualifying events under the above section B occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months.

Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

D. Notice Requirements

If coverage for you or your dependents:

- is being continued for 18 months in accordance with section A; and
- it is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A which would have caused coverage to terminate;

you or your dependent must notify your Employer of such determination within 60 days after the date of the determination, and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent would terminate due to:

- your divorce or termination of domestic partnership;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- the dependent's ceasing to be a dependent child as defined under this Plan;

you or your dependent must provide notice to your Employer of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage

would terminate due to the occurrence of the event.

If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

E. Other Continuation Provisions Under This Plan

If this Plan contains any other continuation provisions which apply when health expense coverage would otherwise terminate, contact your Employer for a description of how the federal and other continuation provisions interact under this Plan.

F. Conversion

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, any Conversion Privilege will be available at the end of such period on the same terms as are applicable upon termination of employment or upon ceasing to be in an eligible class.

Complete details of the federal continuation provisions may be obtained from your Employer.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The last day of the month your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses will be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Health Insurance Portability and Accountability Act of 1996

Use and Disclosure of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules, the Plan Sponsor (Employer) must establish the permitted and required uses of Protected Health Information (PHI). The privacy rules take effect, and require compliance on April 14, 2003.

Restrictions on Disclosure of Protected Health Information to Employer (Plan Sponsor)

The Plan and any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) only to permit the Employer (Plan Sponsor) to carry out plan administration functions for the Plan consistent with the requirements of the Privacy Rule. Any disclosure to and use by the Employer (Plan Sponsor) of Plan Enrollees' Protected Health Information will be subject to and consistent with the provisions of paragraphs on **Employer (Plan Sponsor) Obligations Regarding Protecting Health Information** and **Adequate Separation Between the Employer (Plan Sponsor) and the Plan** of this HIPAA Section.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) unless the disclosures are permitted by law.

The Plan incorporates the following provisions to enable it to disclose the Protected Health Information to the Employer (Plan Sponsor) and acknowledges receipt of written confirmation from the Plan Sponsor that the Plan has been so amended:

Employer (Plan Sponsor) Obligations Regarding Protecting Health Information

The Employer (Plan Sponsor) will:

- Neither use nor further disclose Plan Enrollees' Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.

- Ensure that any agent, including any subcontractor, to whom it provides Plan Enrollees' Protected Health Information received from the group health plan, agrees to the restrictions and conditions that apply to the Employer (Plan Sponsor) with respect to such information.

- Not use or disclose Plan Enrollees' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).

- Report to the Plan any use or disclosure of Plan Enrollees' Protected Health Information that is inconsistent with the uses and disclosures allowed under this HIPAA Section promptly upon learning of such inconsistent use or disclosure.

- Make Protected Health Information available to the Plan Enrollee who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.

- Make Plan Enrollees' Protected Health Information available for amendment, and will upon receipt of written notice amend Plan Enrollees' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.

- Make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

- Make available its internal practices, books, and records, relating to its use and disclosure of Plan Enrollees' Protected Health Information received from the Plan to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Parts 160-64.

- If feasible, return or destroy all Plan Enrollee Protected Health Information received from the Plan that the Employer (Plan Sponsor) maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or disclosure is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure that adequate separation between the Plan and the Employer, as required by 45 Code of Federal Regulations 164.504(f)(2)(iii) is established and maintained.

Adequate Separation Between the Employer (Plan Sponsor) and the Plan

The following employees, classes of employees, or other persons under the control of the Employer (Plan Sponsor) may be given access to Plan Enrollees' Protected Health Information:

- ***Director/Manager of the Personnel Department Benefits Unit and/or designee, and***

- ***Departmental Benefits Representative/Coordinator and/or designee***

This list includes the employee, class of employees or other persons under the control of the Employer (Plan Sponsor) who may receive Plan Enrollees' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The identified employee, classes of employees or other persons will have access to Plan Enrollees' Protected Health Information only to perform the plan administration functions that the Employer (Plan Sponsor) provides for the Plan.

The identified employee, classes of employees or other persons will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (Plan Sponsor), for any use or disclosure of Plan Enrollees' Protected Health Information in breach or violation of or noncompliance with the provisions of this HIPAA Section. Employer (Plan Sponsor) will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other persons causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Enrollee, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.